Heather Horst RN, BSN, CMT

HEALTH AND ENVIRONMENTAL HISTORY

Name _____ Date of birth _____

Address _____ Age: _____

City _____ State _____ Zip _____ Email _____

Main Phone _____ OK to leave voice mail? ☐ No ☐ Yes OK to text? ☐ No ☐ Yes

If you are a remote patient, do you prefer ☐ Facebook video chat on a stationary camera (not a handheld device)

☐ Google Hangouts video chat on a stationary camera (not a handheld device) ☐ Telephone sessions

Do you feel you have Chemical Injuries, Multiple Chemical Sensitivities, Environmental Illness, or a related condition? ☐ No ☐ Yes

Do you know the nature of your first/main exposure?

☐ PESTICIDE ☐ CARPET/RENOVATION ☐ SICK BLDG. ☐ OTHER _____ ☐ UNKNOWN

Please write a narrative describing how/when your illness began.

Describe in time order from the beginning and list dates as often as possible. If one (or more) chemical exposures were involved, describe where you were in relation to it, how long you were exposed, what your symptoms were, and how soon after exposure those symptoms developed.

Please describe your <u>AVERAGE</u> reaction to a chemical exposure.

Describe typical symptoms you experience during such a reaction in the order they occur.

_____

_____

_____

How long does it take before you feel as well as you did before the exposure? _____

How long does it take before you can think as clearly as before it began? _____

How long before you recover energy to do most of your usual activities? _____

EMF Sensitivity: Have you noticed symptoms increase when you are near cell phones, blue tooth devices, wireless modems? ☐ No ☐ Yes ☐ Not Sure

Have you reacted to other electrical or electronic devices? ☐ No ☐ Yes ☐ Not Sure

If yes, what are your symptoms with EMF exposures? _____

_____

_____

For each situation described below, answer the questions at the top of each column. By "sick" we mean anything that YOU consider to be either a major or a minor health problem. Put a check in the appropriate box.

	Would you be sick if you had to spend 4 hours…….?					**Would you be sick if you had to spend 20 minutes …….?**				
	No	A Little	Moder-ately	A Lot	Don't Know	No	A Little	Moder-ately	A Lot	Don't Know
Next to person smoking cigarettes outside										
Driving in heavy traffic with windows open										
Around workers tarring a road										
For the next questions, assume you are inside with no open windows…										
In a room sprayed w/ pesticides 4 hours ago										
In a room painted 24 hours ago with water-based paint										
Shopping in an enclosed mall										
In room with wall/wall carpet 1 week old										
Sitting next to a person wearing perfume / cologne										
Cooking on a stove using natural gas										
Sitting next to someone with fabric softener on clothing										

Would you be sick if you had to …?	No	A Little	Moderately	A Lot	Don't Know
Drink one glass of city (chlorinated) water					
Try on newly dry-cleaned clothing					
Walk down the detergent aisle at a grocery store					
Use self-serve at a gas station					
Use a bathroom with a scented air freshener					
Read a freshly printed newspaper					
Wear synthetic fabrics					
Swim for 20 minutes in a chlorinated pool					
Wear clothing laundered in chlorine bleach					
Wear clothing laundered with scented laundry products					

The above question was assembled from a longer questionnaire used for research by Johns Hopkins (A. Davidoff).

The following asks about symptoms you may have been experiencing. Please rate the severity. (circle one)

0=not at all a problem *5=moderate* *10=disabling*

Problems with your **head**, such as headaches, or a feeling of pressure or fullness in your face or head?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Problems with your **ability to think**, such as difficulty concentrating or remembering things, feeling spacey, or having trouble making decisions?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Problems with your **mood**, such as feeling tense or nervous, irritable, depressed, having spells of crying or rage, or loss of interest in things you used to enjoy?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Problems with **balance or coordination**, with **numbness** or **tingling** in your extremities, or with **focusing your eyes**?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Problems with your **muscles or joints** such as pain, aching, cramping, stiffness or weakness?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Problems with your **skin** such as a rash, hives or dry skin?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Problems with your **urinary tract or genitals**, such as pelvic pain or frequent or urgent urination? Discomfort or other problems with menstrual periods, if you menstruate?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Problems with your **stomach or digestive tract**, such as abdominal pain or cramping, abdominal swelling or bloating, nausea, diarrhea, or constipation?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Problems with your **heart** or chest, such as a fast or irregular heart rate, skipped beats, your heart pounding, or chest discomfort?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Problems with **burning or irritation of your eyes or problems with your airway or breathing**, such as feeling short of breath, coughing, or having a lot of mucus, post nasal damage, or respiratory infections?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Research question from Dr. Claudia Miller

Do you have persistent or relapsing **chronic fatigue**? ☐ No ☐ Yes

If yes, when did this start? Approximate date _____

Do you have fatigue without exerting yourself? ☐ No ☐ Yes ☐ Not Sure

Has your fatigue resulted in a reduction in previous levels of occupational and social activity? ☐ No ☐ Yes

If yes, describe _____

_____

_____

_____

If fatigue is present, what types of activities bring it on, and how soon after starting does the fatigue begin?

_____

_____

_____

If fatigue is present, how long must you rest before you can engage in activities again? _____

Do you feel worse after exercise and exhausted the next day? ☐ No ☐ Yes

Describe your **activities for a relatively typical day** in the past month.

_____

_____

_____

_____

Have you had exposure to **black mold** (stachybotris) at home, work, or school? ☐ No ☐ Yes ☐ Not Sure

If YES, describe.

_____

_____

_____

Have you ever **smoked cigarettes**? ☐ No ☐ Yes

If yes, what year did you begin? _____ How many packs a day on average? _____/day

Have you stopped smoking? ☐ No ☐ Yes If yes, congratulations! What year did you stop? _____

Do you drink beer, wine, or other drinks containing **alcohol**? ☐ No ☐ Yes
If yes, about how many drinks on average in a week? _____

Have you ever had **amalgam** (silver-colored) **dental fillings**?
☐ No, never ☐ Yes, currently ☐ Yes, removed ___ / ____ / _____
month day year

Have you ever taken **birth control pills**? ☐ No ☐ Yes
If Yes, how long? _____ When? _____

Have you ever taken **FluoroQuinolone** antibiotics? (Cipro, Levaquin, Avalox, etc) ? ☐ No ☐ Yes
If Yes, how many times? _____ When was the last time? _____

Have you ever taken psychotropic medications? (Antidepressants, Benzodiazepines, etc.) ☐ No ☐ Yes
If yes, which medication? _____ What year did you begin? _____
Have you been able to stop using them? ☐ No ☐ Yes
If yes, congratulations! What year did you stop? _____
If no, are you interested to learn about protocols for tapering gently and safely? ☐ No ☐ Yes

Home Environment

Check below all that apply to your home	Yes	No	Not Sure		**Yes**	**No**	**Not Sure**
Live in apartment/condo				Attached garage			
Pesticides used in building				Teflon cookware			
Live in mobile home				Aluminum cookware			
Live in detached house you own				Particle board furniture			
Near busy road				Stain-treated upholstery			
Nearby lawn chemicals used				Damp basement			
Carpet (synthetic)				Mold in your house			
Recent painting				Mattress – commercial			
Recent remodeling				Mattress – natural fiber			
Recent pesticide use				Pillow – foam/synthetic			
Fuel space heater (not electric)				Pillow – natural fiber			
Wood stove				Foam stuffed animals, toys			

Have you sorted all your household products and eliminated pesticides, petrochemicals, fragrances, solvents, and other irritating substances from your home? ☐ No ☐ Yes, some ☐ Yes, almost all

Is there anyone in your home who uses products that seem to aggravate your symptoms? ☐ No ☐ Yes
If yes, please describe the situation.

_____

_____

_____

_____

Are you exposed to anything else of concern to you in your neighborhood?

☐ Heavy Traffic ☐ Lawn chemicals ☐ Wood smoke ☐ Nearby fabric softener ☐ Other pollution

Describe concerns _____

_____

_____

Are you exposed to ongoing chemical insults at work or school? ☐ No ☐ Yes

If yes, please describe.

_____

_____

_____

_____

_____

_____

_____

_____

What other problems do you face with your health, if any: physical, emotional, social, financial, sexual, legal, etc.

_____

_____

_____

_____

_____

_____

What is going right with your health?

_____

_____

_____

_____

_____

_____

Regarding your **Gall bladder**, have you ever had…

Gall bladder removal ☐ **No** ☐ **Yes** **G**all stones ☐ **No** ☐ **Yes** Other gall bladder problems ☐ **No** ☐ **Yes**

If other, please describe. _____

Do you have bloating or other difficulty digesting foods with fat/oils in general? ☐ No ☐ Yes

Do you have bloating or other difficulty digesting other foods? ☐ No ☐ Yes

Please list foods that affect you negatively, and describe symptoms.

_____

_____

_____

Do you purchase **foods grown without pesticides**? (Sometimes called Organic)

☐ Yes ☐ No ☐ Yes, sometimes ☐ Yes, regularly

If no, do you know where to obtain pesticide-free foods? What stops you from choosing organic?

_____

_____

_____

Nutrition Log

List below everything you ate & drank for the last 4 days. Include any snacks between meals, and list time of day.

time	**Day 1**	**Day 2**	**Day 3**	**Day 4**

List all nutritional supplements that you are currently taking, the dose and how often you take them, what they are for, if they help, and what bothersome side effects you experience. Please bring the supplement bottle(s) with you to your appointment. (If you are a remote patient, please provide images of the ingredient labels, including "inactive" ingredients.) Also list any prescription drugs.

Name	Dose/ Frequency	Purpose	Helps?	Side Effects

Do you have a nearby non-toxic outdoor area**,** such as a large park or other wooded area, where you can walk without aggravating your symptoms? ☐ No ☐ Yes ☐ Not Sure

If yes**,** are pesticides ever used in these locations? ☐ No ☐ Yes ☐ Not Sure

If not sure**,** please ask the owner/manager of the property before your visit.

How many hours a week, on average, are you outside in a non-toxic area? _____ hours

Are you doing sauna treatments?

☐ No ☐ Yes, at home (Brand?) _____

☐ Yes, commercial sauna ☐ Yes, sauna at medical facility

What other habits and practices currently support your health and wellness?

Please make a list of your questions and goals for this session.

Goals **Questions**

I understand that Heather Horst is a holistic, registered nurse, not a physician.
I understand that she can offer advice or information, but not diagnose disease or prescribe medical treatment.
I consent to receive nursing care in the form of wellness coaching, diet/supplement suggestions, and education.
I affirm that I have provided truthful and accurate information in this questionnaire.

(Patient or guardian) *(date)*

Intake form adapted from Dr. Grace Ziem's questionnaire, with deepest gratitude. ❤